

Reprinted April 6, 2005

ENGROSSED SENATE BILL No. 222

DIGEST OF SB 222 (Updated April 5, 2005 11:47 am - DI 97)

Citations Affected: IC 27-8.

Synopsis: Preexisting condition waivers. Provides that individual and certain group policies of accident and sickness insurance may contain a waiver of coverage for a specified condition under certain circumstances. Specifies that an offer of coverage under a policy that includes a waiver does not preclude eligibility for a comprehensive health insurance association policy.

Effective: July 1, 2005.

Miller, Paul, Riegsecker

(HOUSE SPONSORS — TORR, RIPLEY, BROWN C, NOE)

January 4, 2005, read first time and referred to Committee on Health and Provider Services.

January 13, 2005, amended, reported favorably — Do Pass.
January 24, 2005, read second time, amended, ordered engrossed.
January 25, 2005, engrossed. Read third time, passed. Yeas 47, nays 0.

HOUSE ACTION

March 7, 2005, read first time and referred to Committee on Insurance. March 24, 2005, amended, reported — Do Pass. April 5, 2005, read second time, amended, ordered engrossed.









First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in this style type. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in this style type or this style type reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

ENGROSSED SENATE BILL No. 222

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5-2.7 IS ADDED TO THE INDIANA CODE
AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
1, 2005]: Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter
and any other law, and except as provided in subsection (b), an
individual policy of accident and sickness insurance that is issued
after June 30, 2005, may contain a waiver of coverage for a
specified condition and complications that arise from the specified
condition if:
(1) the waiver period does not exceed ten (10) years; and
(2) all of the following conditions are met:

- - (A) The insurer provides to the applicant before issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.
- (B) The:
- (i) offer of coverage; and
- 17 (ii) policy;

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ES 222-LS 7210/DI 97+









1	include the waiver in a separate section stating in bold
2	print that the applicant is receiving coverage with an
3	exception for the waived condition.
4	(C) The:
5	(i) offer of coverage; and
6	(ii) policy;
7	do not include more than two (2) waivers per individual.
8	(D) The waiver period is concurrent with and not in
9	addition to any applicable preexisting condition limitation
10	or exclusionary period.
11	(E) The insurer agrees to:
12	(i) review the underwriting basis for the waiver upon
13	request one (1) time per year; and
14	(ii) remove the waiver if the insurer determines that
15	evidence of insurability is satisfactory.
16	(F) The insurer discloses to the applicant that the applicant
17	may decline the offer of coverage and apply for a policy
18	issued by the Indiana comprehensive health insurance
19	association under IC 27-8-10.
20	(G) An insurance benefit card issued by the insurer to the
21	applicant includes a telephone number for verification of
22	coverage waived.
23	The insurer shall require an applicant to initial the written notice
24	provided under subdivision (2)(A) and the waiver included in the
25	offer of coverage and in the policy under subdivision (2)(B) to
26	acknowledge acceptance of the waiver of coverage. An offer of
27	coverage under a policy that includes a waiver under this
28	subsection does not preclude eligibility for an Indiana
29	comprehensive health insurance association policy under
30	IC 27-8-10-5.1.
31	(b) An individual policy of accident and sickness insurance may
32	not include a waiver of coverage for a:
33	(1) mental health condition; or
34	(2) developmental disability.
35	(c) An insurer may not, on the basis of a waiver contained in a
36	policy as provided in subsection (a), deny coverage for any
37	condition or complication that is not specified as required in the:
38	(1) written notice under subsection (a)(2)(A); and
39	(2) offer of coverage and policy under subsection (a)(2)(B).
40	(d) An individual who is covered under a policy that includes a
41	waiver under subsection (a) may directly appeal a denial of

coverage based on the waiver by filing a request for an external



42

1	grievance review under IC 27-8-29 without pursuing a grievance	
2	under IC 27-8-28.	
3	(e) An insurer that removes a waiver under subsection (a)(2)(E)	
4	shall not consider the condition or any complication to which the	
5	waiver previously applied in making policy renewal and	
6	underwriting determinations.	
7	(f) Upon the expiration of the waiver period allowed under this	
8	section, the insurer shall:	
9	(1) remove the waiver;	
10	(2) not consider the condition or any complication to which	1
11	the waiver previously applied in making policy underwriting	1
12	determinations; and	,
13	(3) renew the policy in accordance with 45 CFR 148.122.	
14	SECTION 2. IC 27-8-5-19.3 IS ADDED TO THE INDIANA CODE	
15	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY	
16	1, 2005]: Sec. 19.3. (a) This section applies to an association or a	4
17	discretionary group policy of accident and sickness insurance:	1
18	(1) under which a certificate of coverage is issued after June	
19	30, 2005, to an individual member of the association or	
20	discretionary group;	
21	(2) under which a member of the association or discretionary	
22	group is individually underwritten; and	
23	(3) that is not employer based.	
24	(b) Notwithstanding sections 19 and 19.2 of this chapter and any	-
25	other law, and except as provided in subsection (e), a policy	
26	described in subsection (a) may contain a waiver of coverage for a	
27	specified condition and any complications that arise from the	۱
28	specified condition if:	1
29	(1) the waiver period does not exceed ten (10) years; and	
30	(2) all of the following conditions are met:	
31	(A) The insurer provides to the applicant before issuance	
32	of the certificate written notice explaining the waiver of	
33	coverage for the specified condition and complications	
34	arising from the specified condition.	
35	(B) The:	
36	(i) offer of coverage; and	
37	(ii) certificate of coverage;	
38	include the waiver in a separate section stating in bold	
39	print that the applicant is receiving coverage with an	
40	exception for the waived condition.	
41	(C) The:	
42	(i) offer of coverage; and	



1	(ii) certificate of coverage;
2	do not include more than two (2) waivers per individual.
3	(D) The waiver period is concurrent with and not in
4	addition to any applicable preexisting condition limitation
5	or exclusionary period.
6	(E) The insurer agrees to:
7	(i) review the underwriting basis for the waiver upon
8	request one (1) time per year; and
9	(ii) remove the waiver if the insurer determines that
10	evidence of insurability is satisfactory.
11	(F) The insurer discloses to the applicant that the applicant
12	may decline the offer of coverage, and that any individual
13	to whom the waiver would have applied may apply for a
14	policy issued by the Indiana comprehensive health
15	insurance association under IC 27-8-10.
16	(G) An insurance benefit card issued by the insurer to the
17	applicant includes a telephone number for verification of
18	coverage waived.
19	(c) The insurer shall require an applicant to initial the written
20	notice provided under subsection (b)(2)(A) and the waiver included
21	in the offer of coverage and in the certificate of coverage under
22	subsection (b)(2)(B) to acknowledge acceptance of the waiver of
23	coverage.
24	(d) An offer of coverage under a policy that includes a waiver
25	under this section does not preclude eligibility for an Indiana
26	comprehensive health insurance association policy under
27	IC 27-8-10-5.1.
28	(e) A policy described in subsection (a) may not include a waiver
29	of coverage for a:
30	(1) mental health condition; or
31	(2) developmental disability.
32	(f) An insurer may not, on the basis of a waiver contained in a
33	policy as provided in this section, deny coverage for any condition
34	or complication that is not specified as required in the:
35	(1) written notice under subsection (b)(2)(A); and
36	(2) offer of coverage and certificate of coverage under
37	subsection (b)(2)(B).
38	(g) An individual who is covered under a policy that includes a
39	waiver under this section may directly appeal a denial of coverage
40	based on the waiver by filing a request for an external grievance
41	review under IC 27-8-29 without pursuing a grievance under



42

IC 27-8-28.

1	(h) An insurer that removes a waiver under subsection (b)(2)(E)
2	shall not consider the condition or any complication to which the
3	waiver previously applied in making policy renewal and
4	underwriting determinations.
5	(i) Upon the expiration of the waiver period allowed under this
6	section, the insurer shall:
7	(1) remove the waiver;
8	(2) not consider the condition or any complication to which
9	the waiver previously applied in making policy underwriting
10	determinations; and
11	(3) renew the policy in accordance with 45 CFR 148.122.
12	SECTION 3. IC 27-8-10-5.1 IS AMENDED TO READ AS
13	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5.1. (a) A person is not
14	eligible for an association policy if the person is eligible for Medicaid.
15	A person other than a federally eligible individual may not apply for an
16	association policy unless the person has applied for Medicaid not more
17	than sixty (60) days before applying for the association policy.
18	(b) Except as provided in subsection (c), a person is not eligible for
19	an association policy if, at the effective date of coverage, the person has
20	or is eligible for coverage under any insurance plan that equals or
21	exceeds the minimum requirements for accident and sickness insurance
22	policies issued in Indiana as set forth in IC 27. However, an offer of
23	coverage described in IC 27-8-5-2.5(e), or IC 27-8-5-2.7,
24	IC 27-8-5-19.2(e), or IC 27-8-5-19.3 does not affect an individual's
25	eligibility for an association policy under this subsection. Coverage
26	under any association policy is in excess of, and may not duplicate,
27	coverage under any other form of health insurance.
28	(c) Except as provided in IC 27-13-16-4 and subsection (a), a person
29	is eligible for an association policy upon a showing that:
30	(1) the person has been rejected by one (1) carrier for coverage
31	under any insurance plan that equals or exceeds the minimum
32	requirements for accident and sickness insurance policies issued
33	in Indiana, as set forth in IC 27, without material underwriting
34	restrictions;
35	(2) an insurer has refused to issue insurance except at a rate
36	exceeding the association plan rate; or
37	(3) the person is a federally eligible individual.
38	For the purposes of this subsection, eligibility for Medicare coverage
39	does not disqualify a person who is less than sixty-five (65) years of
40	age from eligibility for an association policy.
41	(d) Coverage under an association policy terminates as follows:
42	(1) On the first date on which an insured is no longer a resident of



1	Indiana.
2	(2) On the date on which an insured requests cancellation of the
3	association policy.
4	(3) On the date of the death of an insured.
5	(4) At the end of the policy period for which the premium has
6	been paid.
7	(5) On the first date on which the insured no longer meets the
8	eligibility requirements under this section.
9	(e) An association policy must provide that coverage of a dependent
10	unmarried child terminates when the child becomes nineteen (19) years
11	of age (or twenty-five (25) years of age if the child is enrolled full time
12	in an accredited educational institution). The policy must also provide
13	in substance that attainment of the limiting age does not operate to
14	terminate a dependent unmarried child's coverage while the dependent
15	is and continues to be both:
16	(1) incapable of self-sustaining employment by reason of mental
17	retardation or mental or physical disability; and
18	(2) chiefly dependent upon the person in whose name the contract
19	is issued for support and maintenance.
20	However, proof of such incapacity and dependency must be furnished
21	to the carrier within one hundred twenty (120) days of the child's
22	attainment of the limiting age, and subsequently as may be required by
23	the carrier, but not more frequently than annually after the two (2) year
24	period following the child's attainment of the limiting age.
25	(f) An association policy that provides coverage for a family
26	member of the person in whose name the contract is issued must, as to
27	the family member's coverage, also provide that the health insurance
28	benefits applicable for children are payable with respect to a newly
29	born child of the person in whose name the contract is issued from the
30	moment of birth. The coverage for newly born children must consist of
31	coverage of injury or illness, including the necessary care and treatment
32	of medically diagnosed congenital defects and birth abnormalities. If
33	payment of a specific premium is required to provide coverage for the
34	child, the contract may require that notification of the birth of a child
35	and payment of the required premium must be furnished to the carrier
36	within thirty-one (31) days after the date of birth in order to have the
37	coverage continued beyond the thirty-one (31) day period.
38	(g) Except as provided in subsection (h), an association policy may
39	contain provisions under which coverage is excluded during a period
40	of three (3) months following the effective date of coverage as to a
41	given covered individual for preexisting conditions, as long as medical

advice or treatment was recommended or received within a period of



42

1	three (3) months before the effective date of coverage. This subsection
2	may not be construed to prohibit preexisting condition provisions in an
3	insurance policy that are more favorable to the insured.
4	(h) If a person applies for an association policy within six (6)
5	months after termination of the person's coverage under a health
6	insurance arrangement and the person meets the eligibility
7	requirements of subsection (c), then an association policy may not
8	contain provisions under which:
9	(1) coverage as to a given individual is delayed to a date after the
10	effective date or excluded from the policy; or
11	(2) coverage as to a given condition is denied;
12	on the basis of a preexisting health condition. This subsection may not
13	be construed to prohibit preexisting condition provisions in an
14	insurance policy that are more favorable to the insured.
15	(i) For purposes of this section, coverage under a health insurance
16	arrangement includes, but is not limited to, coverage pursuant to the
17	Consolidated Omnibus Budget Reconciliation Act of 1985.
18	SECTION 4. IC 27-8-29-6 IS AMENDED TO READ AS
19	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this
20	chapter, "external grievance" means the independent review under this
21	chapter of a:
22	(1) grievance filed under IC 27-8-28; or
23	(2) denial of coverage based on a waiver described in
24	IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or
25	IC 27-8-5-19.3.
26	SECTION 5. IC 27-8-29-12 IS AMENDED TO READ AS
27	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall
28	establish and maintain an external grievance procedure for the
29	resolution of external grievances regarding:
30	(1) an adverse determination of appropriateness;
31	(2) an adverse determination of medical necessity;
32	(3) a determination that a proposed service is experimental or
33	investigational; or
34	(4) a denial of coverage based on a waiver described in
35	IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or
36	IC 27-8-5-19.3;
37	made by an insurer or an agent of an insurer regarding a service
38	proposed by the treating health care provider.
39	SECTION 6. IC 27-8-29-13 IS AMENDED TO READ AS
40	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external
41	grievance procedure established under section 12 of this chapter must:
42	(1) allow a covered individual or a covered individual's



1	representative to file a written request with the insurer for an
2	external grievance review of the insurer's:
3	(A) appeal resolution under IC 27-8-28-17; or
4	(B) denial of coverage based on a waiver described in
5	IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or
6	IC 27-8-5-19.3;
7	not more than forty-five (45) days after the covered individual is
8	notified of the resolution; and
9	(2) provide for:
10	(A) an expedited external grievance review for a grievance
11	related to an illness, a disease, a condition, an injury, or a
12	disability if the time frame for a standard review would
13	seriously jeopardize the covered individual's:
14	(i) life or health; or
15	(ii) ability to reach and maintain maximum function; or
16	(B) a standard external grievance review for a grievance not
17	described in clause (A).
18	A covered individual may file not more than one (1) external grievance
19	of an insurer's appeal resolution under this chapter.
20	(b) Subject to the requirements of subsection (d), when a request is
21	filed under subsection (a), the insurer shall:
22	(1) select a different independent review organization for each
23	external grievance filed under this chapter from the list of
24	independent review organizations that are certified by the
25	department under section 19 of this chapter; and
26	(2) rotate the choice of an independent review organization
27	among all certified independent review organizations before
28	repeating a selection.
29	(c) The independent review organization chosen under subsection
30	(b) shall assign a medical review professional who is board certified in
31	the applicable specialty for resolution of an external grievance.
32	(d) The independent review organization and the medical review
33	professional conducting the external review under this chapter may not
34	have a material professional, familial, financial, or other affiliation with
35	any of the following:
36	(1) The insurer.
37	(2) Any officer, director, or management employee of the insurer.
38	(3) The health care provider or the health care provider's medical
39	group that is proposing the service.
40	(4) The facility at which the service would be provided.
41	(5) The development or manufacture of the principal drug, device,
42	procedure, or other therapy that is proposed for use by the treating



1	health care provider.
2	(6) The covered individual requesting the external grievance
3	review.
4	However, the medical review professional may have an affiliation
5	under which the medical review professional provides health care
6	services to covered individuals of the insurer and may have an
7	affiliation that is limited to staff privileges at the health facility, if the
8	affiliation is disclosed to the covered individual and the insurer before
9	commencing the review and neither the covered individual nor the
10	insurer objects.
11	(e) A covered individual shall not pay any of the costs associated
12	with the services of an independent review organization under this
13	chapter. All costs must be paid by the insurer.
14	SECTION 7. IC 27-8-29-15 IS AMENDED TO READ AS
15	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent
16	review organization shall:
17	(1) for an expedited external grievance filed under section
18	13(a)(2)(A) of this chapter, within three (3) business days after
19	the external grievance is filed; or
20	(2) for a standard appeal filed under section 13(a)(2)(B) of this
21	chapter, within fifteen (15) business days after the appeal is filed;
22	make a determination to uphold or reverse the insurer's appeal
23	resolution under IC 27-8-28-17 based on information gathered from the
24	covered individual or the covered individual's designee, the insurer,
25	and the treating health care provider, and any additional information
26	that the independent review organization considers necessary and
27	appropriate.
28	(b) When making the determination under this section, the
29	independent review organization shall apply:
30	(1) standards of decision making that are based on objective
31	clinical evidence; and
32	(2) the terms of the covered individual's accident and sickness
33	insurance policy.
34	(c) In an external grievance described in section 12(4) of this
35	chapter, the insurer bears the burden of proving that the insurer
36	properly denied coverage for a condition, complication, service, or
37	treatment because the condition, complication, service, or treatment is
38	directly related to a condition for which coverage has been waived
39	under IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or

(d) The independent review organization shall notify the insurer and

the covered individual of the determination made under this section:



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41 42 IC 27-8-5-19.3.

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and (2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.	
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SENATE MOTION

Madam President: I move that Senator Paul be added as second author of Senate Bill 222.

MILLER

SENATE MOTION

Madam President: I move that Senator Riegsecker be added as coauthor of Senate Bill 222.

MILLER

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 222, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 3, delete lines 5 through 7.

Page 4, delete lines 40 through 42.

and when so amended that said bill do pass.

(Reference is to SB 222 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 2.











SENATE MOTION

Madam President: I move that Senate Bill 222 be amended to read as follows:

- Page 1, line 7, after "(1) the" insert "waiver".
- Page 1, line 7, delete "for which the exemption would be in effect".
- Page 3, between lines 4 and 5, begin a new paragraph and insert:
- "(d) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (e) Upon the expiration of the waiver period allowed under this section, the insurer:
 - (1) shall remove the waiver;
 - (2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
 - (3) shall renew the policy in accordance with 45 CFR 148.122.".
 - Page 3, line 19, after "(1) the" insert "waiver".
 - Page 3, line 19, delete "for which the exemption would be in effect".
 - Page 4, between lines 36 and 37, begin a new paragraph and insert:
- "(g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (h) Upon the expiration of the waiver period allowed under this section, the insurer:
 - (1) shall remove the waiver;
 - (2) shall not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
 - (3) shall renew the policy in accordance with 45 CFR 148.122.".

(Reference is to SB 222 as printed January 14, 2005.)

MILLER











COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred Senate Bill 222, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, line 3, delete "," and insert "and any other law,".

Page 1, line 6, delete ":".

Page 1, delete line 7.

Page 1, line 8, delete "(2)".

Page 1, run in lines 6 through 8.

Page 1, line 9, delete "(A)", begin a new line block indented and insert:

"(1)".

Page 1, line 12, delete ", including a specific" and insert ".".

Page 1, delete lines 13 through 14.

Page 1, line 15, delete "(B)", begin a new line block indented and insert:

"(2)".

Page 1, line 16, delete "(i)", begin a new line double block indented and insert:

"(A)".

Page 1, line 17, delete "(ii)", begin a new line double block indented and insert:

"(B)".

Page 2, line 1, beginning with "include" begin a new line block

Page 2, line 3, delete "and specifying each" and insert ".".

Page 2, delete lines 4 through 5.

Page 2, line 6, delete "(C)", begin a new line block indented and insert:

"(3)"

Page 2, line 7, delete "(i)", begin a new line double block indented and insert:

"(A)"

Page 2, line 8, delete "(ii)", begin a new line double block indented and insert:

"(B)".

Page 2, line 9, beginning with "do" begin a new line block indented.

Page 2, line 10, delete "(D)", begin a new line block indented and insert:

"(4)".

ES 222-LS 7210/DI 97+











Page 2, line 13, delete "(E)", begin a new line block indented and insert:

"(5)".

Page 2, line 13, delete ":" and insert "review the waiver upon request if:

- (A) the individual to whom the waiver applies has not received medical advice, diagnosis, care, or treatment related to the waived condition; and
- (B) no recommendation has been made to the individual to whom the waiver applies that the individual should receive medical advice, diagnosis, care, or treatment related to the waived condition;

for at least two (2) years.".

Page 2, delete lines 14 through 17.

Page 2, line 18, delete "(F)", begin a new line block indented and insert:"

"(6)".

Page 2, delete lines 22 through 23.

Page 2, line 24, delete "(H)", begin a new line block indented and insert:

"(7)".

Page 2, line 28, delete "(2)(A)" and insert "(1)".

Page 2, line 29, delete "(2)(B)" and insert "(2)".

Page 2, delete lines 35 through 42, begin a new paragraph and insert:

- "(b) Notwithstanding subsection (a), an individual policy of accident and sickness insurance may not include a waiver of coverage for a:
 - (1) mental health condition; or
 - (2) developmental disability.".

Page 3, delete lines 1 through 14.

Page 3, line 19, delete "after June".

Page 3, line 20, delete "30, 2005,".

Page 3, line 25, delete "," and insert "and any other law,".

Page 3, line 28, delete ":".

Page 3, delete line 29.

Page 3, line 30, delete "(2)".

Page 3, run in lines 28 through 30.

Page 3, line 31, delete "(A)", begin a new line block indented and insert:

"(1)".

Page 3, line 34, delete ", including a specific" and insert ".".

ES 222-LS 7210/DI 97+











Page 3, delete lines 35 through 36.

Page 3, line 37, delete "(B)", begin a new line block indented and insert:

"(2)".

Page 3, line 38, delete "(i)", begin a new line double block indented and insert:

"(A)".

Page 3, line 39, delete "(ii)", begin a new line double block indented and insert:

"(**B**)".

Page 3, line 40, beginning with "include" begin a new line block indented.

Page 3, line 42, delete "and specifying each" and insert ".".

Page 4, delete lines 1 through 2.

Page 4, line 3, delete "(C)", begin a new line block indented and insert:

"(3)"

Page 4, line 4, delete "(i)", begin a new line double block indented and insert:

"(A)".

Page 4, line 5, delete "(ii)", begin a new line double block indented and insert:

"(B)".

Page 4, line 6, beginning with "do" begin a new line block indented. Page 4, line 7, delete "(D)", begin a new line block indented and insert:

"(4)".

Page 4, line 10, delete "(E)", begin a new line block indented and insert:

"(5)".

Page 4, line 10, delete ":" and insert "review the waiver upon request if:

- (A) the individual to whom the waiver applies has not received medical advice, diagnosis, care, or treatment related to the waived condition; and
- (B) no recommendation has been made to the individual to whom the waiver applies that the individual should receive medical advice, diagnosis, care, or treatment related to the waived condition;

for at least two (2) years.".

Page 4, delete lines 11 through 14.

Page 4, line 15, delete "(F)", begin a new line block indented and

ES 222—LS 7210/DI 97+







insert: "(6)". Page 4, line 16, after "and" insert "that". Page 4, delete lines 20 through 21. Page 4, line 22, delete "(H)", begin a new line block indented and insert: "(7)". Page 4, line 26, delete "(b)(2)(A)" and insert "(b)(1)". Page 4, line 28, delete "(b)(2)(B)" and insert "(b)(2)". Page 4, delete lines 30 through 41. Page 4, line 42, delete "(f)" and insert "(d)". Page 5, delete lines 4 through 14, begin a new paragraph and insert: "(e) Notwithstanding subsection (b), a policy described in subsection (a) may not include a waiver of coverage for a: (1) mental health condition; or (2) developmental disability.". Page 7, delete lines 21 through 42. Delete pages 8 through 9. Page 10, delete lines 1 through 9. Page 10, line 10, delete "," and insert "and IC 27-8-5-19.3, both". Page 10, line 11, delete "applies" and insert "apply". Page 10, delete lines 13 through 42. Delete page 11. Renumber all SECTIONS consecutively. and when so amended that said bill do pass. (Reference is to SB 222 as reprinted January 25, 2005.)

RIPLEY, Chair

Committee Vote: yeas 5, nays 3.



HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 222 be amended to read as follows:

Page 1, line 4, after "," insert "and except as provided in subsection (b),".

Page 1, line 5, after "insurance" insert "that is issued after June 30, 2005,".

Page 1, line 6, after "and" insert "any".

Page 1, line 7, delete "all of the following conditions are met:" and insert ":

- (1) the waiver period does not exceed ten (10) years; and
- (2) all of the following conditions are met:".

Page 1, line 8, delete "(1)", begin a new line double block indented and insert:

"(A)".

Page 1, line 9, delete "a".

Page 1, line 12, delete "(2)", begin a new line double block indented and insert:

"(B)".

Page 1, line 13, delete "(A)", begin a new line triple block indented and insert:

"(i)".

Page 1, line 14, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 1, line 15, beginning with "include" begin a new line double block indented.

Page 2, line 1, delete "(3)", begin a new line double block indented and insert:

"(**C**)".

Page 2, line 2, delete "(A)", begin a new line triple block indented and insert:

"(i)".

Page 2, line 3, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 2, line 4, beginning with "do" begin a new line double block indented.

Page 2, line 5, delete "(4)", begin a new line double block indented and insert:

"(D)".

ES 222-LS 7210/DI 97+









Page 2, line 8, delete "(5)", begin a new line double block indented and insert:

"(E)".

Page 2, line 8, delete "to review the waiver upon request if:" and insert "to:

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 2, delete lines 9 through 16.

Page 2, line 17, delete "(6)", begin a new line double block indented and insert:

"(F)".

Page 2, line 21, delete "(7)", begin a new line double block indented and insert:

"(G)".

Page 2, line 25, delete "(1)" and insert "(2)(A)".

Page 2, line 26, delete "(2)" and insert "(2)(B)".

Page 2, line 31, delete "Notwithstanding subsection (a), an" and insert "An".

Page 2, between lines 35 and 36, begin a new paragraph and insert:

- "(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition or complication that is not specified as required in the:
 - (1) written notice under subsection (a)(2)(A); and
 - (2) offer of coverage and policy under subsection (a)(2)(B).
- (d) An individual who is covered under a policy that includes a waiver under subsection (a) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.
- (e) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (f) Upon the expiration of the waiver period allowed under this section, the insurer shall:
 - (1) remove the waiver;
 - (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
 - (3) renew the policy in accordance with 45 CFR 148.122.".



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Page 2, line 40, after "issued" insert "after June 30, 2005,".

Page 3, line 4, after "," insert "and except as provided in subsection (e),".

Page 3, line 5, after "and" insert "any".

Page 3, line 6, delete "all of the following conditions are" and insert ":

(1) the waiver period does not exceed ten (10) years; and

(2) all of the following conditions are met:".

Page 3, delete line 7.

Page 3, line 8, delete "(1)", begin a new line double block indented and insert:

"(A)".

Page 3, line 9, delete "a".

Page 3, line 12, delete "(2)", begin a new line double block indented and insert:

"(B)".

Page 3, line 13, delete "(A)", begin a new line triple block indented and insert:

"(i)".

Page 3, line 14, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 3, line 15, beginning with "include" begin a new line double block indented.

Page 3, line 18, delete "(3)", begin a new line double block indented and insert:

"(C)".

Page 3, line 19, delete "(A)", begin a new line triple block indented and insert:

"(i)".

Page 3, line 20, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 3, line 21, beginning with "do" begin a new line double block indented.

Page 3, line 22, delete "(4)", begin a new line double block indented and insert:

"(D)".

Page 3, line 25, delete "(5)", begin a new line double block indented and insert:

"(E)".

Page 3, line 25, delete "review the waiver upon request if:" and

ES 222—LS 7210/DI 97+









insert ":

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 3, delete lines 26 through 33.

Page 3, line 34, delete "(6)", begin a new line double block indented and insert:

"(F)"

Page 3, line 39, delete "(7)", begin a new line double block indented and insert:

"(G)".

Page 4, line 1, delete "(b)(1)" and insert "(b)(2)(A)".

Page 4, line 3, delete "(b)(2)" and insert "(b)(2)(B)".

Page 4, line 9, delete "Notwithstanding subsection (b), a" and insert "A".

Page 4, between lines 12 and 13, begin a new paragraph and insert:

- "(f) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition or complication that is not specified as required in the:
 - (1) written notice under subsection (b)(2)(A); and
 - (2) offer of coverage and certificate of coverage under subsection (b)(2)(B).
- (g) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.
- (h) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (i) Upon the expiration of the waiver period allowed under this section, the insurer shall:
 - (1) remove the waiver;
 - (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
 - (3) renew the policy in accordance with 45 CFR 148.122.".

Page 6, delete lines 19 through 22, begin a new paragraph and insert:

"SECTION 4. IC 27-8-29-6 IS AMENDED TO READ AS



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FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

- (1) grievance filed under IC 27-8-28; or
- (2) denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3.

SECTION 5. IC 27-8-29-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

- (1) an adverse determination of appropriateness;
- (2) an adverse determination of medical necessity;
- (3) a determination that a proposed service is experimental or investigational; or
- (4) a denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3;

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 6. IC 27-8-29-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

- (1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:
 - (A) appeal resolution under IC 27-8-28-17; or
 - (B) denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or IC 27-8-5-19.3;

not more than forty-five (45) days after the covered individual is notified of the resolution; and

- (2) provide for:
 - (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:
 - (i) life or health; or
 - (ii) ability to reach and maintain maximum function; or
 - (B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance







of an insurer's appeal resolution under this chapter.

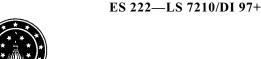
- (b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:
 - (1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and
 - (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.
- (c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.
- (d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:
 - (1) The insurer.
 - (2) Any officer, director, or management employee of the insurer.
 - (3) The health care provider or the health care provider's medical group that is proposing the service.
 - (4) The facility at which the service would be provided.
 - (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.
 - (6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 7. IC 27-8-29-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within three (3) business days after











the external grievance is filed; or

- (2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed; make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.
- (b) When making the determination under this section, the independent review organization shall apply:
 - (1) standards of decision making that are based on objective clinical evidence; and
 - (2) the terms of the covered individual's accident and sickness insurance policy.
- (c) In an external grievance described in section 12(4) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3.
- (d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:
 - (1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and
 - (2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 222 as printed March 25, 2005.)

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